Testimony of Oliver Mayorga, MD
To the Committee on Human Services regarding Amendment
Section 17b-239 Connecticut General Statutes
Raised Bill No. 236
March 1, 2012

An Act Concerning Reimbursement Rates to Physicians Who Provide Emergency Room Services to Medicaid Recipients:

My name is Oliver Mayorga, MD. I am an Emergency Physician. I am with EMP, a group that staffs ER's in Stamford, New London and Meriden, as well as more than 50 other hospitals around the country.

I am testifying here today in support of Raised Bill No. 236. The issues addressed by this bill were raised in 2007 and 2010 and remain unresolved. In addition, a new issue has now appeared: complete denial of enrollment in the Connecticut Medicaid Program for emergency physician groups like mine.

Emergency medicine is the country's newest medical specialty. When we discuss the evolution of that specialty, forty years ago is ancient history, predating specialty training in emergency medicine, board certification in emergency medicine, or even the notion that emergency medicine might really be a specialty. Forty years ago, emergency departments were staffed by interns and residents in training, or physicians starting out in practice who needed some income while they were building a private practice outside the hospital. Any physician who practiced in the emergency room did so as an employee of the hospital. It wasn't until the 1970's that emergency medicine began to evolve, as a specialized medical field, and organizationally as a new business model. The first emergency medicine residencies were established in the 1970's and the American Board of Emergency Medicine was officially recognized by the American Board of Medical Specialties in 1979. Whereas emergency medicine practice had previously been considered merely a way station for a physician on his or her way to private practice in some other specialty, the country now saw growing numbers of physicians, like myself, who elected to devote their careers to emergency medicine. The evolution of the medical specialty also brought with it an evolution of the predominant business model. Instead of hiring physicians as employees, hospitals began contracting with groups of career emergency physicians who brought new expertise to the care which the hospitals could offer to patients coming to the emergency department.

EMP embraces that model. In 2002, we began staffing the ER at Stamford Hospital. Since that time we believe EMP has clearly demonstrated, that independent emergency physician groups are in a better position to dedicate and manage staffing, clinical resources and education into providing quality and state-of-the-art emergency services and should be encouraged to provide services for hospitals and health systems in the State of Connecticut.

Under this arrangement, the emergency physicians provide medical care to all ER patients, with the only compensation coming from the professional fees that are collected by our own billing and collection activities. The physicians are not employees of the hospital and do not receive any compensation from the hospital for caring for our patients. Our compensation comes from what we collect from patients and/or their insurers. It is fair to say that although the hospital employee model of emergency medicine is far from extinct, the

predominant model of emergency physician staffing in the United States is now a private practice model in which the hospital contracts with a group of emergency physicians. For reasons which someone wiser than I might be able to explain, the employee model has remained much more prevalent in the Northeastern United States than in most other areas of the country, which brings me to the reason for proposal of this this bill.

Payment Issues

Under the current DSS payment policies, when emergency physicians in Connecticut treat a Medicaid patient in the ER, the DSS will only pay the hospital but will not pay the emergency physician who has actually treated the patient. This arrangement was created under the assumption, perhaps understandable and acceptable years ago, that the physicians treating Medicaid patients in the emergency room were all hospital employees, paid by the hospital, which in turn was being paid a fee which encompassed all of the costs the hospital incurred in providing emergency room service, including the payments the hospital made to the emergency physicians. In other words, to use the current terminology of medical billing, payments for the technical and professional components of the service provided were one and the same.

The inequity of this policy derives from the fact that these assumptions are no longer valid or applicable to a growing number of emergency physician groups. Moreover, the assumption that the hospital is actually collecting the "professional component" is also faulty, since the hospital does not compensate our physicians for these services, and does not carry any such amounts on the cost reports which determine the hospital's payments.

We do not receive professional fees from the hospital. We understand that if we don't do a good job, if we don't provide proper care, if we don't meet the needs of our patients, we won't get paid. What our physicians don't understand, what I don't understand, is how DSS can justify not paying us for medical services we are providing to its beneficiaries.

Adding insult to injury, DSS payment policies differ dramatically with respect to the services provided by other "hospital-based physicians" (which includes radiologists, pathologists and anesthesiologists), who function under the same private practice group model, contracting with the hospital, as we do. For example, if an EMP physicians treats a Medicaid patient who has a fever, chest pain, shaking chills and a productive cough; orders a chest x-ray which shows pneumonia; then treats the patient with antibiotics and arranges for the patient to be admitted to the hospital as an inpatient, DSS will pay the EMP physician who treated the patient nothing, but will nevertheless pay a professional fee to the radiologist who interpreted the x-ray. The irony is that under current DSS policy and practice, DSS will pay the radiologist who may never actually see the patient, while the emergency physician who actually sees and treats the patient gets nothing. Privately employed pathologists, anesthesiologists and other physicians who provide care to Medical Assistance Program patients are treated in a fashion similar to radiologists. Only the emergency medicine physician is denied reimbursement for professional services in this situation.

Another area we are trying to address concerns is the unfair payment policy applied to emergency physicians when a patient is admitted to the hospital. Emergency Departments are considered an out-patient area of a hospital. DSS policy states: "[t]he per diem reimbursement rate is the all inclusive payment in full for all services provided to [Medical Assistance Program] recipients when they are inpatients." I have attached a copy of DSS Medical Services Policy 150,

marked as **Exhibit A**, to my testimony. In other words, DSS holds that the per diem fee paid to the hospital is all that will be paid; the emergency physician gets nothing. However, if an internist or family physician sees that same very sick patient and provides the same evaluation and arranges for the patient to be admitted to the hospital, DSS will pay the office-based physician for the same services for which DSS will pay the emergency physician nothing, again based on the erroneous assumption that we are salaried employees of the hospital. But yet, this Medical Services Policy also contains an exception permitting physicians that are not providing services as salaried hospital employees to bill.

Lest there be any question as to the legitimacy and acceptability of the private practice model I have attached to my testimony DSS Provider Bulletin 2004-76 as **Exhibit B**, which specifically recognizes that hospitals contracting with private physicians or physician groups to provide emergency department coverage constitute an acceptable arrangement for Medicaid billing purposes. Presently, at least four of Connecticut's 31 acute care hospitals staff their emergency departments in this manner and more are expected to follow. This is clearly in contradiction to DSS assertions that even independent emergency department physicians should simply look to the hospital for payment.

Enrollment Issues

These payment issues have been festering for a number of years, but DSS has now presented us with a new obstacle which adds insult to injury. EMP was recently denied enrollment in Connecticut Medicaid for our newest practice site in Meriden, at MidState Medical Center. This denial of enrollment has placed a significant financial burden on not only EMP but also on the hospital that now must try and formulate some type of arrangement to compensate EMP. If emergency physician groups are unable to enroll and bill Connecticut Medicaid, it could ultimately affect access to emergency services in the State of Connecticut by making it financially difficult, if not impossible, for hospitals to attract qualified independent emergency physicians. EMP currently staffs emergency departments in 12 states and in no other state has EMP faced this issue.

To make matters worse, DSS has now dis-enrolled us in Stamford, even though we have been enrolled there since 2002. It gets worse. This past December we received written notice from DSS that our re-enrollment date would be postponed until August. However, last week DSS notified us not only that our re-enrollment was denied, but that they were dis-enrolling us retroactively back to February 6, 2012 and that all claims after that date would be denied. However you look at it, this is just wrong. It's inherently unfair and gave us no prior notice or opportunity to appeal the action.

In summary, DSS payment and enrollment policies differ dramatically with respect to the services provided by other "hospital-based physicians" (which includes radiologists, pathologists and anesthesiologists), who function under the same private practice group model, contracting with the hospital, as we do. These specialty groups are permitted to be enrolled and paid separately for their services. Only emergency physicians are treated differently. Our emergency physicians and other similarly situated emergency medicine physician groups throughout Connecticut would benefit from the proposed amendment by requiring that <u>any</u> physician who provides professional services to a Medicaid beneficiary in the emergency room of a hospital be paid separately from the payment made to hospital for the provision of services. I think we all can agree that hospital emergency departments and the physicians who staff them provide very

important services to the citizens of Connecticut who rely on the Medical Assistance Program. It is only fair then that DSS compensate the parties for the medical and professional services they provide. Raised Bill No. 236 will help ensure that this remains the case without exception. I have attached a revised copy of Raised Bill No. 236 to this Testimony which is marked as **Exhibit C.**

(b) Field Audit

Field audits will be performed on a timetable determined by the Department. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost report is accurate, complete and reasonable. The field audits are conducted in conformity with Medicare regulations and are of sufficient scope to determine that only proper items of cost applicable to the services furnished were included in the provider's calculation of its cost and to determine whether the expense attributable to such proper items of cost were accurately determined to be reasonable.

Any item not supported by adequate documentation or which is found to be unallowable will be disallowed by field audit. Proper adjustments to future payments will be made to recover amounts determined by field audit to be overpayments.

8. Whenever a Medicare cost report is reopened, the result of the reopening will be applied to the Medicaid cost report.

9. Notwithstanding any of the above provisions, any requirements mandated by changes in Federal law applicable to the Medicaid program shall be hereby incorporated into these regulations and shall supersede any contrary provision of these regulations.

10. Charges to the General Public

The State is not authorized to pay a hospital for services in excess of charges made by such hospital for comparable services to the general public.

11. Hospital Inpatient Per Diem Rate Covers All Inpatient Services

The per diem reimbursement rate is the all inclusive payment in full for all services provided to recipients when they are inpatients. This includes hospital based physician and dental fees. The exception is physicians and dentists that are not providing services as salaried staff by the hospital. These services may be billed by the physician or dentist to the Medicaid program.

Connecticut Department of Social Services
Medical Assistance Program
Provider Bulletin

PB 2004-76 November 2004

TO: Physicians, Hospital Providers and Managed Care Organizations

SUBJECT: Billing Protocol for Services Provided in Emergency Rooms by Physicians Not Enrolled in Medicaid

It has come to the Department's attention that there have been occasions when non-participating physicians (i.e. not enrolled as Connecticut Medicaid providers) have rendered services in hospital emergency rooms and have subsequently billed Medicaid clients directly for those services. This Bulletin is to clarify that per the Connecticut Medical Assistance Program provider agreement hospitals are obligated to provide hospital services to Medicaid clients. These services include both the professional and technical components associated with the delivery of services in an emergency room.

Typically, hospitals bill for professional services rendered by hospital staff in the emergency room using Revenue Center Code (RCC) 981 (Professional Fee/ Emergency Room). However, there are instances where hospitals have opted to contract with a physician or physician group for emergency room coverage instead. This is an acceptable arrangement; however, the hospital is still ultimately responsible for the provision of services and under no circumstances should a physician or physician group bill the client directly for those services.

If a hospital chooses to enter into a separate arrangement with a physician or physician group to provide the professional component of emergency room services, the hospital should either ensure that the provider is enrolled in Medicaid or bill for the professional component using RCC 981. If the hospital bills using RCC 981, it should make payment arrangements directly with the physician or physician group.

General Assembly

February Session, 2012

Raised Bill No. 236

LCO No. **1067**

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Referred to Committee on Human Services

Introduced by:

(HS)

AN ACT CONCERNING REIMBURSEMENT OF EMERGENCY ROOM PHYSICIANS FOR TREATMENT OF MEDICAID RECIPIENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (d) of section 17b-239 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(d) The state shall also pay to such hospitals for each outpatient clinic and emergency room visit a reasonable rate to be established annually by the commissioner for each hospital, such rate to be determined by the reasonable cost of such services. The Commissioner of Social Services shall set and provide a separate and distinct rate to an emergency room physician who (1) provides professional services to a Medicaid beneficiary in the emergency room of a hospital, including services provided on the same day that the beneficiary is admitted to the hospital and (2) is not compensated by the hospital, either, through ~~does not receive~~ a salary or ~~subsidy~~ a percentage of fees collected, to provide such services in the hospital. The rate paid by the Commissioner for the emergency room physician's professional services shall be reimbursed separately from the rate paid to such hospital for the emergency room visit. The emergency room visit rates in effect June 30, 1991, shall remain in effect through June 30, 1993, except those which would have been decreased effective July 1, 1991, or July 1, 1992, shall be decreased. Nothing contained herein shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios in effect June 30, 1991, shall be reduced effective July 1, 1991, by the most recent annual increase in the consumer price index for medical care. For those outpatient hospital services paid on the basis of a ratio of cost to charges, the ratios computed to be effective July 1, 1994, shall be reduced by the most recent annual increase in the consumer price index for medical care. The emergency room visit rates in effect June 30, 1994, shall remain in effect through December 31, 1994. The Commissioner of Social Services shall establish a fee schedule for outpatient hospital services to be effective on and after January 1, 1995, and may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to hospitals in the aggregate and

ensures patient access. Utilization shall not be a factor in determining cost neutrality. Except with respect to the rate periods beginning July 1, 1999, and July 1, 2000, such fee schedule shall be adjusted annually beginning July 1, 1996, to reflect necessary increases in the cost of services. Notwithstanding the provisions of this subsection, the fee schedule for the rate period beginning July 1, 2000, shall be increased by ten and one-half per cent, effective June 1, 2001. Notwithstanding the provisions of this subsection, outpatient rates in effect as of June 30, 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006, subject to available appropriations, the commissioner shall increase outpatient service fees for services that may include clinic, emergency room, magnetic resonance imaging, and computerized axial tomography.

Section 2. Subsection (e) of section 17b-239 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2012*):

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing criteria for defining emergency and nonemergency visits to hospital emergency rooms. All nonemergency visits to hospital emergency rooms shall be paid at the hospital's outpatient clinic services rate. The Commissioner shall also adopt regulations, in accordance with the provisions of chapter 54, establishing enrollment requirements for emergency room physicians who are not compensated by a hospital, either through a salary or percentage of fees collected, to provide professional services in the emergency room of a hospital so that such physicians may enroll in the medical assistance program and bill for their services. Such enrollment requirements shall not require that the physician maintain a practice at a location other than the hospital or perform services at another location besides the hospital. Nothing contained in this subsection or the regulations adopted hereunder shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public.

Explanation for additional changes (in red) to Subsection (d):

The proposed language in (d)(1) makes clear that emergency room physicians would be paid for professional services rendered in the emergency room in circumstances where the patient is subsequently admitted to the hospital on the same day. The proposed language in (d)(2) follows the language in the DSS Provider Manual for Hospitals (Chapter 7) requiring that the physician not be fully or partially salaried by the hospital.

Explanation for additional changes (in red) to Subsection (e):

The proposed language in the subsection address issues raised by R.C.S.A. § 17b-262-524(g) which permits providers who are (1) compensated directly or indirectly by an institution or general hospital or (2) located within an institution or general hospital to bill DSS for services rendered to medical assistance program beneficiaries in the

hospital only if certain criteria are met. These criteria include the provider maintaining a practice at a location other than the hospital and performing services that are billed to the medical assistance program at the other location. Most emergency room physicians practice exclusively in a hospital setting, making it impossible for them to meet these criteria.